



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

PATIENT CARE INJURY CLINIC

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-16-2604-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

APRIL 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for lack of precertification... It is quite evident that the carrier is unwilling to reimburse our facility for medical bills that were authorized."

Amount in Dispute: \$302.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. Provider failed to get preauth prior to rendering the services. See attached."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 11, 2016	97110-GP and 97140-GP	\$302.06	\$232.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
- 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – payment denied/reduced for absence of precertification/authorization
 - 199 – Number of services exceed utilization agreement
 - 119 – Benefit maximum for this time period or occurrence has been reached
 - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services

Issues

1. What defenses did the insurance carrier raise during the medical bill review process?
2. Did the requestor submit documentation to support that preauthorization was obtained for the disputed services?
3. Is the insurance carrier’s denial/reduction code(s) supported?
4. Did the requestor bill in accordance with 28 Texas Administrative Code §134.203?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code’s 97110-GP and 97140-GP rendered on February 11, 2016. Review of the submitted documentation finds that the insurance carrier denied/reduced the disputed services with denial/reduction codes:
 - 197 – Payment denied/reduced for absence of precertification/authorization
 - 199 – Number of services exceed utilization agreement
 - 119 – Benefit maximum for this time period or occurrence has been reached
 - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
2. 28 Texas Administrative Code §134.600 (p) states in pertinent part, “Non-emergency health care requiring preauthorization includes... (5) physical and occupational therapy services...”

Review of the preauthorization letters provided by the requestor and the insurance carrier finds the following:

Date	Utilization Review	Services Requested	Services Authorized or Denied	Authorized Timeframes
1/27/2016	Sedgwick	PT 3 times a week for 4 weeks	Certify 4 PT sessions as medically necessary	1/25/2016 thru 3/7/2016
2/16/2016	Unknown	Unknown	Non-certification-Peer review doctor, dated 3/9/2016 referred to this denied peer review	None
3/9/2016	Sedgwick	PT 3 times a week for 2 weeks (CPT Codes 97110, 97112 & 97140)	Non-certification	None

Review of the submitted documentation supports that the disputed date of service, February 11, 2016 was provided within the preauthorized timeframes. Insufficient documentation was submitted by the insurance carrier to support that the provider exceeded the allowed timeframes and/or sessions. As a result, the disputed services are subject to review pursuant to 28 Texas Administrative Code §134.203 (b).

3. 28 Texas Administrative Code §134.203 (b) states in pertinent part, “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

The Division completed NCCI edits to identify potential edit conflicts that would affect reimbursement. The requestor billed the following CPT Codes on February 11, 2016; 97110-GP, 97140-GP, 97112-GP and G0283. The Division finds that no NCCI edits were identified, as a result reimbursement is calculated pursuant to 28 Texas Administrative Code §134.203 (c).

4. 28 Texas Administrative Code §134.203 states in pertinent part, “(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...”

To determine reimbursement, the Division applies Medicare's payment policies for physical therapy services. Per MLN Matters® Number: MM7050, with an Implementation Date: January 3, 2011, the following policies apply: "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings... The reduction applies to the HCPCS codes contained on the list of 'always therapy' services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services... The MPPR applies to the codes on the list of procedures included with CR7050 as Attachment 1. CR7050 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf>."

CPT codes 97110-GP and 97140-GP are identified on the "always therapy" code list and are therefore subject to the MPPR. Reimbursement is calculated as follows:

Procedure code 97110, service date February 11, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.44264. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.92029 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$52.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$39.72 at 4 units is \$158.88. Therefore, the amount is recommended.

Procedure code 97140, service date February 11, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.43817. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.006 is 0.4024. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.85012 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$48.30. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$36.87 at 2 units is \$73.74. Therefore, the amount is recommended.

Procedure code 97112, service date February 11, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.006 is 0.48288. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.96053 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$54.58. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$54.58. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$53.38. The insurance carrier issued payment in the amount of \$53.38. The requestor does not identify this procedure code on the table of disputed services, however in order to identify the procedure with the highest PE this procedure is included in the calculation.

Procedure code G0283, service date February 11, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.18342. The practice expense (PE) RVU of 0.2 multiplied by the PE GPCI of 1.006 is 0.2012. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.39417 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$22.40. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$16.68. The insurance carrier issued payment in the amount of \$22.00. The requestor does not identify this procedure code on the table of disputed services, however in order to identify the procedure with the highest PE this procedure is included in the calculation. The Division finds that the requestor is entitled to reimbursement in the amount of \$232.62.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$232.62.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$232.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	Date

May 20, 2016

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The Division within twenty days of your receipt of this decision must receive the request. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.